2008

Buu Nguyen v. Pulmonetic Systems, Inc., a Delaware Corporation, IHC Health Services, Inc., a Utah Corporation dba Primary Children's Medical Center, University of Utah Hospitals and Clinics, University of Utah and State of Utah : Brief of Appellee

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

BUU NGUYEN,

Plaintiff/Appellant,

vs.

PULMONETIC SYSTEMS, INC., a Delaware Corporation, IHC HEALTH SERVICES, INC., a Utah Corporation dba PRIMARY CHILDREN'S MEDICAL CENTER, UNIVERSITY OF UTAH HOSPITALS AND CLINICS, UNIVERSITY OF UTAH AND STATE OF UTAH

Defendants/Appellees.

Appellate Case No. 20080738

District Court Case No. 030901469

BRIEF OF APPELLEES UNIVERSITY OF UTAH HOSPITALS AND CLINICS, UNIVERSITY OF UTAH AND STATE OF UTAH

APPEAL FROM SUMMARY JUDGMENT
THIRD JUDICIAL DISTRICT COURT, SALT LAKE COUNTY, STATE OF UTAH
HONORABLE SANDRA N. PEULER

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JURISDICTION

This is an appeal from an order striking Plaintiff's expert witness and from orders granting summary judgment in a civil case. This Court has jurisdiction pursuant to Utah Code Ann. § 78A-4-103(2)(j) (2008).

ISSUES PRESENTED FOR REVIEW

1. Did the trial court abuse its discretion in striking Dr. John Goldenring as an expert witness? "The trial court has discretion to determine the admissibility of expert testimony, and to determine if the witness is qualified to give an opinion on a particular matter." *Anton v. Thomas*, 806 P.2d 744, 746 (Utah Ct. App. 1991) (quotations and citations omitted).

2. Did the trial court err in granting summary judgment in favor of the Defendants on Plaintiff's causes of action and claim for punitive damages? "For summary judgment to be appropriate there must be no genuine issue of material fact. The moving party must be entitled to judgment as a matter of law. When reviewing a grant of summary judgment, we view the facts in the light most favorable to the non-moving party. We grant no deference to the district court's conclusions of law and review them for correctness." *Bowman v. Kalm*, 2008 UT 9, ¶ 6, 179 P.3d 754.

RELEVANT STATUTES AND RULES

Utah R. Evid. 702

> (a) Subject to the limitations in subsection (b), if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, ***a witness qualified as an expert by knowledge, skill,***

experience, training, or education may testify thereto in the form of an opinion or otherwise.

(b) Scientific, technical or other specialized knowledge may serve as the basis for expert testimony if the scientific, technical, or other principles or methods underlying the testimony ***meet a threshold showing that they (i) are reliable, (ii) are based on sufficient facts or data, and (iii) have been reliably applied to the facts of the case.***

(c) The threshold showing required by subparagraph (b) is satisfied if the principles or methods on which such knowledge is based, including the sufficiency of facts or data and the manner of their application to the facts of the case, are generally accepted by the relevant expert community.

(Emphasis added.)

Utah Code Ann. § 63G-7-603(1)(a) (2008):

A judgment may not be rendered against a governmental entity for exemplary or punitive damages.

STATEMENT OF THE CASE

NATURE OF CASE

This is a medical malpractice case arising from one-year old Derek Nguyen's ("Derek") November 24-26, 2001 hospitalization at Primary Children's Medical Center ("PCMC") following a motor vehicle accident in which Derek sustained life-threatening injuries. (R. at 80-92.) On November 26, 2001, a pediatric transport ventilator that was being used on Derek suddenly lost power. (R. at 5-6.). Despite attempts to resuscitate Derek, he died approximately 45 minutes later. (R. at 806, 816.)

Plaintiff's claims against Defendants University of Utah Hospitals and Clinics, University of Utah and State of Utah (collectively the "University Defendants") arise from the alleged acts and omissions of Dr. Madolin Witte, the physician responsible for

managing Derek's treatment and care in the pediatric intensive care unit ("PICU") at PCMC. (R. at 65, 793.) Dr. Witte is an employee of the University of Utah School of Medicine who was acting within the course and scope of her employment in providing treatment and care to Derek. (R. at 65, 785.)

COURSE OF PROCEEDINGS AND DISPOSITION BY TRIAL COURT

On January 27, 2003, Plaintiff filed a Complaint against the University Defendants, PCMC and the manufacturer of the pediatric transport ventilator, Pulmonetic Systems, Inc. ("Pulmonetic"). (R. at 1-12.) Plaintiff's claims against Pulmonetic were dismissed with prejudice after those two parties reached a settlement. (R. at 203-209.)

Plaintiff asserted causes of action for negligence, failure to obtain informed consent and intentional infliction of emotional distress against the University Defendants and PCMC. Plaintiff also asserted a claim for punitive damages. (R. at 88-91.) PCMC filed motions for partial summary judgment with respect to Plaintiff's cause of action for intentional infliction of emotional distress and claim for punitive damages. (R. at 525-616, 617-669.) The University Defendants joined both motions. (R. at 689-692, 694-735.) At a July 23, 2008 hearing, the trial court granted the motions. (R. at 3400 at pp. 72-74, 84-85.) The Court's rulings are reflected in two orders entered on August 14, 2008. (R. at 3381-3383, 3387-3388.)

The University Defendants filed a motion strike Dr. John Goldenring as an expert witness. (R. at 738-871.) PCMC joined that motion. (R. at 959-1061.) Following a hearing, the trial court granted the motion in an eight-page Ruling dated July 29, 2008.

(R. at 2589-2596.) The trial court's Ruling is reflected in an order entered on August 15, 2008. (R. at 3392-3394.)

After the trial court struck Dr. Goldenring, PCMC filed a motion for summary judgment with respect to Plaintiff's two remaining causes of action for negligence and failure to obtain informed consent. (R. at 2746-2906.) The University Defendants joined the motion. (R. at 2907-2909.) The trial court granted the motion at an August 1, 2008 hearing. (R. at 3531 at pp. 13-14—Tr. of 8/1/08 Hearing.) The trial court's ruling is reflected in an order that was entered on August 15, 2008. (R. at 3396-3398.)

STATEMENT OF FACTS

DEREK'S MEDICAL CONDITION AND HIS HEALTH CARE PROVIDERS

1. On November 24, 2001, Derek was transported to PCMC via helicopter and admitted to the PICU with multiple life-threatening injuries, including a degloving scalp laceration, facial lacerations, fractured skull, a brain injury, contusions to both lungs and lacerations to intra-abdominal organs. (R. at 807-807, 3400 at p. 4.)

2. Dr. Madolin Witte was Derek's attending physician at PCMC. Dr. Witte is an employee of the University of Utah School of Medicine, where she has held faculty appointments in the Division of Pediatric Critical Care and Division of Pediatric Pulmonary Medicine for the past 20 years. Dr. Witte's clinical practice of medicine is limited to providing inpatient critical care and pulmonary care to pediatric patients at PCMC. (R. at 785, 793.)

3. After graduating from medical school, Dr. Witte completed residency training in pediatrics, followed by fellowship training in pediatric pulmonary medicine and pediatric critical care medicine. Dr. Witte is board certified in pediatrics. She also holds subspecialty board certifications in both pediatric critical care medicine and pediatric pulmonology. (R. at 786, 788.)

4. During Derek's three-day hospitalization, Dr. Witte obtained consultations from other physicians about various aspects of Derek's medical condition. The consulted physicians were from trauma surgery, neurosurgery, orthopedic surgery, ophthalmology, cardiology and plastic surgery. Dr. Witte also received input about Derek's condition from a PICU fellow, PICU residents, respiratory therapists and PICU nurses. (R. at 793, 3400 at p. 6.)

5. While Dr. Witte obtained input from many other health care providers, she retained ultimate responsibility for making decisions about Derek's treatment and care. (R. at 793.)

6. Derek's two most pressing medical problems were his brain injury and injury to his lungs. The brain injury had caused swelling and elevated intracranial pressures ("ICPs"), which were being monitored. Elevated ICPs can cause inadequate blood supply to the brain, resulting in permanent neurologic injury or death. The adequacy of blood perfusion to Derek's brain was also being monitored and measured in units of cerebral perfusion pressure ("CPPs"). (R. at 791, 794, 806, 845.)

7. Despite aggressive treatment of Derek's brain injury, his elevated ICPs and low CPPs worsened. By November 26, Derek's ICPs were in the mid to high twenties. A normal ICP is under fifteen. Derek's CPPs were in the forties. Even a brain injured patient should have a CPP of sixty. Derek's low CPPs caused Dr. Witte to be concerned about brain injury from inadequate perfusion of Derek's brain. In Dr. Witte's clinical judgment, Derek's ICPs and CPPs were not conducive to a good neurologic outcome. (R. at 795, 808-809.)

8. Dr. Witte's assessment of the likely effect of Derek's elevated ICPs and low CPPs on his neurologic function were based on Dr. Witte's experience as a pediatric critical care physician and her knowledge of the medical literature in that area. (R. at 795-796.)

9. Derek's respiratory failure required him to be intubated and placed on a ventilator. Oxygen saturation levels in Derek's tissues were being measured. Like his head injury, Derek's respiratory condition and oxygen saturation levels worsened during his hospitalization. By November 26, Derek's bedside ventilator had to be set at a very high pressure to adequately inflate his lungs. Specifically, a pressure of 60 was required to inflate Derek's lungs. A normal inflation pressure would be in the teens. Despite this extreme pressure setting, Derek's oxygen saturation levels were not adequate. (R. at 804, 806-807, 809.)

10. Complicating matters for Dr. Witte was a concern that treatment of Derek's brain injury was compounding his lung injury and vise versa. Specifically, Dr. Witte was

concerned that measures being taken to increase Derek's CPP could be causing or contributing to poor heart function. In fact, by November 26, Dr. Witte was concerned that Derek could go into cardiopulmonary arrest within hours. Dr. Witte was also concerned that Derek's poor heart function and the treatment of his lung injuries with high pressure ventilation may be causing elevated ICPs. (R. at 791, 795. 804, 806, 809.)

DECISION TO OBTAIN A BRAIN CT SCAN

11. Dr. Witte's assessment of Derek's worsening cardiopulmonary and brain conditions led her to question whether a different course of treatment should be pursued. In particular, Dr. Witte questioned whether an intracranial bleed or a blood clot in Derek's brain was causing his worsening ICPs and CPPs. If so, surgery could be performed to treat the bleeding or clotting. If. however. bleeding or clotting was not present and the swelling of Derek's brain was not severe, Dr. Witte planned to shift gears and focus on maximizing treatment of Derek's lung and heart injuries by placing him on a different type of ventilator that can generate very high pressures. (R. at 795-796. 807.)

12. By the afternoon of November 26. Dr. Witte believed that it was "very critical" to obtain a brain CT scan to assess possible causes for Derek's worsening ICPs and CPPs and to evaluate whether a different type of ventilator should be used. In Dr. Witte's professional judgment. a CT scan was a prerequisite to any new course of treatment. (R. at 791. 795. 807-809.)

13. Derek had to be transported from the PICU for a CT scan. While Dr. Witte knew that transporting Derek involved risk. she concluded that the risk of not doing a CT

scan exceeded the risk of the transport. In fact, Dr. Witte believed there was a high likelihood that Derek would die if a CT scan was not performed in the afternoon of November 26, 2001. Dr. Witte's conclusion about the necessity of obtaining a CT scan was based on both the severity and instability of Derek's condition. (R. at 796, 802-804.)

USE OF PULMONETIC VENTILATOR DURING TRANSPORT

14. To transport Derek to the CT scanner. it was necessary to use a portable ventilator. After receiving input from other health care providers. including the PICU fellow, PICU residents, respiratory therapists and PICU nurses, Dr. Witte decided to use a ventilator manufactured by Pulmonetic because it was the only available transport ventilator that could provide the level and mode of ventilation support Derek required. (R. at 789, 791, 793-794, 799, 812.)

15. The Pulmonetic ventilator is approved by the FDA for use on pediatric patients in intensive care units and for use in transporting pediatric patients. Further, the ventilator is used at other pediatric hospitals to transport critically ill patients from the PICU to the CT scanner. (R. at 805, 1882-1883, 1898.)

16. When asked what she would have done if the Pulmonetic ventilator had not been available. Dr. Witte testified:

> Well. it's hard to say not knowing what his course would have been. but I would have been reluctant to try to transport him on a different ventilator because in our experience it didn't support patients with this severity of lung disease very reliably. and so I think it was possible that had he continued to worsen our hand might have been forced and we would have tried to do that anyway. I think at that particular

> moment in time had that ventilator not been available I would not have taken him for CT scan.

(R. at 790).

17. Before Derek was transported to the CT scanner, his father was advised that (1) Dr. Witte thought it was important to obtain a CT scan; (2) Derek would have to be transported for the CT scan; and (3) there was risk involved in transporting Derek out of the PICU. After being informed about the risks and benefits of the CT scan and transport, Derek's father responded by saying, "Do what you can to save my son." (R. at 1889, 1907.)

18. Prior to being transported to the CT scanner, Derek was placed on the Pulmonetic ventilator in the PICU and monitored for approximately an hour. During that time, it was confirmed that the ventilator was duplicating the level of support provided by Derek's bedside ventilator. (R. at 790. 808, 813-814.)

19. While Dr. Witte had no concerns about the Pulmonetic ventilator's performance, she acknowledges that transporting a patient outside of the PICU always presents a risk to the patient's ventilation status. Dr. Witte further acknowledges that all ventilators malfunction periodically for various reasons. For that reason, transports are always made with emergency equipment so that the patient can be manually ventilated if necessary. (R. at 796. 1255. 1890. 1892.)

20. A number of people accompanied Derek during his transport to and from the CT scanner, including Derek's father. Dr. Witte, the PICU fellow, a respiratory

therapist, a pediatric Life Flight nurse, a PICU nurse and a representative from Pulmonetic. (R. at 794, 797, 804, 820.)

21. After the CT scan was completed, Derek was being transported back to the PICU when the Pulmonetic ventilator suddenly lost power. A respiratory therapist involved in the transport immediately began manually ventilating Derek with a bag, but Derek did not respond. Upon arrival at the PICU, Derek was placed on a high pressure bedside ventilator. Efforts to resuscitate Derek over a 45 minute time period were not successful. (R. at 797, 815-817, 821.)

22. A subsequent investigation conducted by Pulmonetic concluded that the ventilator most likely lost power as a result of a screw making contact with the ventilator's motherboard and causing it to short circuit. The investigation did not reveal any misuse of the ventilator, and the lead investigator testified that the health care providers could not have known about the screw problem. (R. at 824-827.)

23. Dr. Witte testified that if she had the decision to make all over again, she would still order the use of the Pulmonetic ventilator. (R. at 793.)

PCMC'S EVALUATION OF VENTILATORS FOR PURCHASE

24. In July 2001, PCMC began considering the purchase of a new pediatric transport ventilator. The anticipated initial use of the new ventilator was on patients being transported on Life Flight, but it was also anticipated that the new ventilator would eventually replace transport ventilators being used in the hospital. (R. at 1881, 2004-2005, 3242-3243.)

25. PCMC has an organized process for gathering and reviewing information about equipment to assist it in making a purchasing decision. This process is called Clinical Technology Management ("CTM process"). The CTM process is recommended but is not mandatory. (R. at 1982, 2016.)

26. The stated purpose of the CTM process is to "[c]reate an integrated system for management of clinical equipment within and between IHC facilities which optimally coordinates and focuses the diverse elements of the 'equipment life cycle.' These elements include technology Planning, Assessment, Acquisition, Utilization, Maintenance and Disposition." (R. at 3232.)

27. A committee was formed to participate in a CTM process for evaluating and selecting a new transport ventilator. Members of the committee included Dr. Witte, nurses, respiratory therapists, clinical engineering personnel and finance department personnel. The committee established both clinical and nonclinical criteria for evaluating the ventilators. The committee eventually selected two ventilators, the Pulmonetic ventilator and the Cross Vent ventilator, for clinical evaluations. (R. at 787, 1881, 1983-1986. 3241-3243. 3249-3254.)

28. In preparation for the clinical evaluations. the committee discussed the need to engage PCMC's risk management department in a discussion regarding the need for parental approval for participation in the clinical evaluations. but the CTM committee notes do not reflect that parental approval was ultimately required. Dr. Witte testified that she does not believe informed consent was required for purposes of conducting the

clinical evaluations. The chairperson of the CTM committee, Tammy Bleak. R.N., similarly testified that she did not intend to have parents of patients who participated in the clinical evaluations sign a consent form. (R. at 789. 1910. 3174.)

29. While Dr. Witte was not involved in any CTM committee discussions about the type of patient that would be selected to participate in the clinical evaluations. her understanding was that moderately ill patients would be selected because they most closely represent the population of patients transported on Life Flight. The record does not reflect any decision being made by the CTM committee to preclude use of the Pulmonetic ventilator on other types of patients. including critically ill or unstable patients. (R. at 800-801. 2639. 3171-3174.)

30. Dr. Witte is unaware of any hospital policy that would have prohibited her from using the Pulmonetic ventilator on Derek. Further, there is nothing in the record to indicate that the ventilator was to be used only for purposes of conducting the CTM clinical evaluations. (R. at 793. 1263. 1272.)

31. Dr. Witte's decision to use the Pulmonetic ventilator on Derek was outside the scope of the CTM process. Dr. Witte made it clear to those involved in transporting Derek that they were not using the ventilator as part of the CTM process. For that reason. no CTM evaluation forms were used. (R. at 1885.)

32. Dr. Witte viewed the ventilator as an FDA approved medical device that would help her obtain information that was necessary to make treatment decisions for

Derek. Dr. Witte testified that the decision to use the ventilator was not based on anything other than what she believed to be in Derek's best interest. (R. at 1885, 1895.)

33. The chairperson of the CTM committee, Tammy Bleak, R.N., denied having any quality assurance responsibility for new equipment. Nurse Bleak testified that when new equipment comes to PCMC from the manufacturer, it is considered to be "worthy to be used" on patients after PCMC's clinical engineering department performs a basic electrical safety inspection. An electrical safety inspection was completed on the Pulmonetic ventilator. (R. at 1242, 1914.)

34. The clinical engineer who performed the electrical safety inspection of the Pulmonetic ventilator, Ramsey Worman, did not express any disagreement with the decision to use the Pulmonetic ventilator on patients. Mr. Worman did, however, confirm that the clinical engineering department was not capable of testing the operational functioning of the Pulmonetic ventilator and that the department must rely on manufacturers to ensure that new equipment operates correctly. (R. at 1915-1916.)

35. Another member of the CTM committee who is a respiratory care manager confirmed that specification testing is not performed and that it is "assumed that the manufacturer is providing us with a safe and sound piece of equipment." (R. at 2026.)

DR. JOHN GOLDENRING'S EDUCATION, TRAINING & EXPERIENCE

36. Plaintiff's sole expert is Dr. John Goldenring. After graduating from medical school, Dr. Goldenring completed residency training in pediatrics followed by a fellowship in adolescent medicine. Adolescent medicine physicians treat patients ranging

in age from 9 to 25 years. Dr. Goldenring has never had residency or fellowship training in pediatric critical care medicine or pediatric pulmonology, and he is not board certified in either of those subspecialties. (R. at 856, 859.)

37. Dr. Goldenring has no active privileges to admit patients to any hospital or to practice medicine in any hospital. The last time Dr. Goldenring had active hospital privileges was sometime between 2001 and 2003, and the last time he used hospital privileges was in 1995. (R. at 860.)

38. While Dr. Goldenring claims to have worked in hospitals similar to PCMC such as Los Angeles Children's Hospital, San Diego Children's Hospital and Galveston Children's Hospital, the record does not establish that Dr. Goldenring worked in a PICU at any of those hospitals. (R. at 1927-1928.)

39. From 1983 to 1994, Dr. Goldenring practiced general pediatrics. The record reflects that his only experience in a PICU was between 1987 and 1991. During that period of time, Dr. Goldenring would round on his general pediatric patients if they were hospitalized, but he always got lots of help from specialists, including critical care physicians. Dr. Goldenring acknowledges that "It's not appropriate for a general pediatrician to take on a really bad case, even in the old days, without getting lots of help." Dr. Goldenring also agrees that the current standard requires patients such as Derek to be managed by critical care physicians. (R. at 845, 857, 1927, 1931-1932.)

40. Since 1994, Dr. Goldenring has primarily worked as an administrator and consultant for health maintenance organizations ("HMO") and individual practice

associations ("IPA"), where his work is focused on maintaining contracts with health care providers and ensuring that those providers follow HMO and IPA rules. (R. at 1928-1930, 1933, 2151.)

41. Dr. Goldenring has never worked as a hospital administrator. Further, he has never been involved as a member of a hospital committee that evaluated new equipment for purchase. Moreover, Dr. Goldenring has no experience writing protocols for evaluations of new equipment. Finally, the record does not reflect that Dr. Goldenring reviewed any documents created by the CTM committee in this case. (R. at 1928-1930, 2151.)

42. The record does not indicate that Dr. Goldenring has any experience reviewing the quality of care provided by pediatric critical care physicians or in reviewing the quality of care provided by any other type of health care provider in a PICU setting. (R. at 1314-1315.)

43. While Dr. Goldenring claims to have been "involved in informed consent issues of all kinds for many years," the record does not reflect that he has any experience in obtaining informed consent for the transport of PICU patients. (R. at 1338.)

OPINIONS REGARDING NECESSITY OF CT SCAN

44. In his deposition, Dr. Goldenring expressed a number of opinions regarding the standard of care for Dr. Witte. Dr. Goldenring's first criticism is that a CT scan was not critical at the time it was ordered by Dr. Witte. (R. at 851, 854.)

45. The basis for Dr. Goldenring's opinion is his interpretation of Dr. Witte's response to a hypothetical question of what she would have done if the Pulmonetic ventilator had not been available. (R. at 851. 854.)

46. Dr. Goldenring admits that he is not an expert in ICPs. Dr. Goldenring formed his opinions about the treatment and care provided to Derek without reviewing what his ICPs were over the course of his hospitalization. (R. at 843-844. 846-847. 853.)

47. When asked in his deposition what a normal ICP would be for Derek. Dr. Goldenring could not provide an answer. When pressed on the issue of ICPs, Dr. Goldenring responded, "What I'm telling you is that that is an [critical care]-anesthesiologist and neurosurgical issue for me. That's not my major area of expertise and I wouldn't tell you that it was." (R. at 845.)

48. Dr. Goldenring acknowledges that CPPs are very important. but again admits that he is not an expert in that area. When asked what a target CPP would be for Derek. Dr. Goldenring could not provide an answer. Dr. Goldenring further testified that critical care physicians and neurosurgeons manage CPPs because "they are the ones that actually know that stuff. much better than I have ever forgotten." (R. at 847.)

OPINIONS REGARDING CONSULTATION WITH OTHER PROVIDERS

49. Dr. Goldenring opines that Dr. Witte breached the standard of care by failing to consult with Derek's multidisciplinary team of providers before making the decision to transport him for a CT scan. In particular. Dr. Goldenring believes a neurosurgeon should have been consulted. (R. at 854-855. 1346-1349. 1363.)

50. One basis for Dr. Goldenring's opinion is his prior PICU experience. Specifically, Dr. Goldenring testified, "That's what we do in the ICU. We stand next to the patient and look at the chart together and we go okay and we try to come to a consensus on what to do next. That's the team approach. I'm assuming they used that approach." (R. at 854, 1363.)

51. Another basis for Dr. Goldenring's opinion is guidelines promulgated by the American Association for Respiratory Care ("AARC") for transporting ventilated patients. In particular, Dr. Goldenring relies on the following guideline: "The necessity and safety for transport should be assessed by the multidisciplinary team of health care providers, e.g. respiratory therapist, physician nurse." (R. at 1346, 3143.)

52. When asked about the authoritativeness of the AARC guidelines, Dr. Goldenring testified, "There's a lot of things that go into the standard of care, and I rarely will say that a guideline on its own absolutely determines everything because there's also case-by-case issues, but they're very relevant, I think." (R. at 1342.)

OPINIONS REGARDING METHOD OF VENTILATION

53. In Dr. Goldenring's opinion, Dr. Witte should have used a different means of ventilation if it became necessary to transport Derek for a CT scan. In particular, Dr. Goldenring believes it would have been reasonable and safe to hand bag Derek during the transport. (R. at 838, 850-851,1352.)

54. The basis for Dr. Goldenring's opinion is his prior PICU experience. Dr. Goldenring testified that hand bagging was "the old way of doing things." He claims to

have consulted with a pulmonologist to confirm that hand bagging is still used to transport PICU patients. Dr. Goldenring also relies on AARC guidelines for transporting ventilated patients in support of his opinion. (R. at 850-851, 861, 1352.)

55. Goldenring admits that he is not a ventilator expert and that he has never used the Pulmonetic ventilator. Dr. Goldenring does, however, agree that not all ventilators would have met Derek's requirements. Dr. Goldenring defers to the respiratory therapists at PCMC as to whether any available ventilator besides the Pulmonetic ventilator could have been used. (R. at 850-852.)

OPINIONS REGARDING "HOSPITAL RULES"

56. In Dr. Goldenring's opinion, Dr. Witte breached the standard of care by failing to comply with "hospital rules" allegedly established by the CTM committee. Dr. Goldenring specifically opines that Dr. Witte breached the standard of care by using the Pulmonetic ventilator on a critically ill patient. (R. at 854-855, 862, 864.)

57. When asked to cite to a PCMC policy limiting use of the Pulmonetic ventilator to moderately ill patients, Dr. Goldenring was unable to do so. Instead, Dr. Goldenring relies on deposition testimony from Dr. Witte regarding the type of patient that was to be selected to participate in the CTM clinical evaluations. (R. at 864-865.)

OPINIONS REGARDING INFORMED CONSENT

58. Dr. Goldenring acknowledges that risks of transport were discussed with Derek's father but questions whether a language barrier prevented Derek's father from fully understanding the information that was shared with him. Dr. Goldenring

acknowledges that he saw no discussion in the record as to how good Derek's father understood English. (R. at 855, 1322.)

59. Dr. Goldenring also opines that Dr. Witte breached the standard of care by failing to advise Derek's father of the risks of using an "untested" ventilator that was being evaluated by the CTM committee. Dr. Goldenring also opines that Dr. Witte did not fully advise Derek's father of the risks of a ventilator malfunction. (R. at 1291, 1317-1318, 1322-1323.)

60. A basis for Dr. Goldenring's opinions regarding informed consent is his interpretation of a PCMC publication titled, "Let's Talk About . . . patient and family rights." This one-page handout advises patients' parents that they have a right to be "informed about your child's current diagnosis, treatment and any known outcome." The handout further advises parents that they have the right to participate in their child's plan of care and "in collaboration with your physician, to make decisions to accept or refuse medical care as permitted by law, and to be informed of the medical consequences of such refusals." (R. at 855, 1317-1318, 1323, 3146.)

61. A critical care physician retained by the University as an expert witness, Dr. Stephen Schexnayder, testified in his deposition that the standard of care did not require Dr. Witte to obtain informed consent for use of the Pulmonetic ventilator. Dr. Schexnayder specifically testified that the Pulmonetic ventilator is like any other piece of FDA approved medical equipment that is routinely used to treat hospital patients without informed consent. (R. at 834.)

CAUSATION OPINIONS

62. Dr. Goldenring opines that the Defendants' breaches of the standard of care caused Derek's death. (R. at 1318.)

63. The basis for Dr. Goldenring's opinion is his interpretation of Dr. Witte's deposition testimony about a conference with Derek's father following Derek's death. Dr. Witte's testimony follows:

> I think there was a clear temporal relationship between the ventilator malfunction and his deterioration, but I was trying to emphasize that it was the timing rather than the eventual outcome, that someone who had less severe injuries would not—would have tolerated a brief interruption of ventilation. ***So I shared with him that I couldn't say that the ventilator caused his death, and that I think without the trip to the CT scan there was a high likelihood that he would die***, but the timing of his death was probably influenced by the ventilator malfunction.

(R. at 1318-1319, 1892. Emphasis added.)

64. Dr. Goldenring agrees that any opinion on what Derek's outcome would have been absent the ventilator malfunction would be speculative. When asked during his deposition if he could give an opinion within a reasonable degree of medical certainty as to whether Derek would have survived absent the ventilator malfunction. Dr. Goldenring responded. "It's very difficult to say that. He certainly had a chance of survival. I'm not sure that I can give you a number. I'm not sure that I have enough intensive care experience to do that." (R. at 856.)

SUMMARY OF ARGUMENT

This case arises from medical treatment decisions made by Dr. Witte. Dr. Goldenring is not qualified to criticize those decisions or to otherwise testify as an expert against Dr. Witte. Furthermore, Dr. Goldenring's opinions are not supported by the facts. Without the support of competent expert testimony, Plaintiff's causes of action for negligence and failure to obtain informed consent fail as a matter of law. Plaintiff's informed consent claim also fails because the facts establish that informed consent was obtained and because the status of the CTM process is not a material medical risk that must be disclosed. The record does not support a cause of action for intentional infliction of emotional distress or a claim for punitive damages. Furthermore, the University Defendants are immune from liability for punitive damages.

ARGUMENT

I. TRIAL COURTS ARE CHARGED WITH A DUTY TO SCREEN OUT UNQUALIFIED AND UNRELIABLE EXPERT TESTIMONY

Rule 702 of the Utah Rules of Evidence governs the admissibility of expert testimony. The rule assigns to trial courts "a gatekeeper responsibility to screen out unreliable expert testimony. In performing their gatekeeper function, trial courts are instructed to confront proposed expert testimony with rational skepticism." Utah R. Evid. 702 advisory committee's note (quotations omitted); *Franklin v. Stevenson*, 1999 UT 61, ¶ 12, 987 P.2d 22. While rational skepticism is not defined by either Rule 702 or Utah case law, the dictionary definition of skepticism is "'(1) doubting attitude: an attitude marked by a tendency to doubt what others accept to be true.'" John R. Lund &

Keith A. Kelley, *Skeptics at the Gate—The 2007 Revisions to Rule 702, Utah Rules of Evidence*, Vol. 21, No. 4 Utah Bar Journal, 33, 36 (2008) (citation omitted). It has also been suggested that rational skepticism should include the query: "Why should I believe this?" *Id.* (citing *State v. Palumbo*, 327 A.2d 613, 617 (Me. 1974)).

Expert testimony must clear two hurdles before it may be admitted at trial. *See Alder v. Bayer Corp.*, 2002 UT 115, ¶ 59, 61 P.3d 1068 (placing burden of establishing admissibility of expert testimony on party seeking to present the testimony). First, under Rule 702(a), the proposed expert witness must be qualified to offer expert testimony through "knowledge, skill, experience, training or education." Utah R. Evid. 702(a) . Second, under Rule 702(b), expert testimony must be (1) reliable; (2) based upon sufficient facts or data; and (3) have been reliably applied to the facts of the case. Utah R. Evid. 702(b).[1]

While the trial court focused on Rule 702(a) in striking Dr. Goldenring, Rule 702(b) arguments were also presented to the court. (R. at 769, 971, 3400 at pp. 31-33, 51-53.) This Court may affirm the trial court's order striking Dr. Goldenring on the basis of Rule 702(a), Rule 702(b) or any other grounds apparent from the record. *See Wall v. Morris*, 2008 UT App 333, ¶ 3, 193 P.3d 1060.

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[1] Rule 702 was amended in 2007. Previously, Rule 702(b) challenges went to the weight of testimony, not its admissibility. Under the amended rule, expert testimony must satisfy the Rule 702(b) requirements before it may be admitted at trial. *See* John R. Lund & Keith A. Kelley, *Skeptics at the Gate—The 2007 Revisions to Rule 702, Utah Rules of Evidence*, Vol. 21, No. 4 Utah Bar Journal, 33, 36 (2008).

II. DR. GOLDENRING IS NOT QUALIFIED TO OFFER EXPERT OPINIONS AGAINST DR. WITTE

"By definition, an expert is one who possesses significant depth and breadth of knowledge on a given subject." *Dikeou v. Osborn*, 881 P.2d 943, 947 (Utah Ct. App. 1994). Trial courts are given discretion under Rule 702(a) to determine if a witness is qualified to testify as an expert. *Id.; Anton v. Thomas*, 806 P.2d 744, 746 (Utah Ct. App. 1991) (affirming trial court's finding that expert was not qualified). The record shows that Dr. Goldenring is not qualified to testify as an expert witness against Dr. Witte.

A. Dr. Goldenring and Dr. Witte Have Different Medical Specialties

A Rule 702(a) analysis must begin with a consideration of Dr. Goldenring's medical education, training and board certifications. The general rule regarding medical expert witnesses is that a practitioner from one specialty is not competent to testify as an expert against a practitioner from another specialty. *See, e.g., Burton v. Youngblood*, 711 P.2d 245, 248 (Utah 1985). While Dr. Goldenring and Dr. Witte are both pediatricians, their subspecialty certifications and clinical practices are very different. Dr. Goldenring's clinical experience was in general pediatrics and adolescent medicine. Dr. Witte is board certified in both pediatric critical care medicine and pediatric pulmonology, and her clinical practice is limited to those subspecialties in a critical care, inpatient hospital setting. She is not a general pediatrician.

The Utah Supreme Court was presented with a similar distinction in expert qualifications in *Burton*. The defendant in that case was a general plastic surgeon who

performed upper eyelid surgery on the plaintiff. *Id.* at 247. The plaintiff's expert was an ocular plastic surgeon. *Id.* Even though both physicians were plastic surgeons, the more qualified ocular plastic surgeon was not allowed to testify as an expert against the general plastic surgeon because adequate foundation was not laid to establish that the same methods and standards of care in performing the surgery at issue applied to both specialists. *Id.* at 248-49.

Plaintiff appears to recognize there are significant differences in education, training and practice areas between Dr. Witte and Dr. Goldenring and therefore argues that the Court should look beyond training and board certifications to determine if Dr. Goldenring is qualified to testify as an expert. An exception to the general rule applies if it can be established that the method of treatment, and hence the standard of care, is identical in different medical specialties such that a practitioner from one specialty would be knowledgeable about the standard of care in the other specialty. *Arnold v. Curtis*, 846 P.2d 1307, 1310 (Utah 1993).

B. The General Rule Applies Without Exception in This Case

In *Patey v. Lainhart*, 1999 UT 31, 977 P.2d 1193, the Utah Supreme Court applied the exception to the general rule in affirming the trial court's decision to allow a general dentist who treated the plaintiff to testify as an expert on the issue of whether an automobile accident caused the plaintiff to need root canal therapy. *Id.* at ¶¶ 4-8. On appeal, the defendant challenged the expert's competency to testify and argued that the proposed expert was a general dentist and not an endodontic specialist. *Id.* at ¶ 17.

The Utah Supreme Court affirmed the trial court's order allowing the general dentist to testify after concluding that the plaintiff had sufficiently established that the general dentist was qualified, both through formal training and actual practice in endodontics, to give expert opinions in that area of dentistry. *Id.* at ¶ 18. In support of its ruling, the Utah Supreme Court noted that one-fourth of the expert's dental education related to endodontics; that he had maintained ongoing educational study of endodontic procedures; that he was licensed to perform endodontic procedures; and that endodontics constituted a substantial portion of the expert's 36-year practice. *Id.*

Similarly, in *Boice v. Marble*, 1999 UT 71, 982 P.2d 565, the issue was whether a neurosurgeon was qualified to testify as an expert against a physiatrist with respect to post-operative care provided to the patient following spinal surgery. *Id.* at ¶¶ 13-15. The court allowed the neurosurgeon to testify because he established that the standard of care for the post-surgical care at issue is the same regardless of whether it is provided by a physiatrist or a neurosurgeon. *Id.* In other cases where a sufficient foundation was not laid for the exception to the general rule, courts have refused to allow the proposed expert to testify. *See, e.g., Evans v. Langston*, 2007 UT App 240, ¶ 12, 166 P.3d 621 (holding anesthesiologist not qualified to testify as an expert on causation issues related to coronary artery disease).

Unlike *Patey*, the record in this case demonstrates that Dr. Goldenring does not have similar training as Dr. Witte or any experience practicing pediatric critical care medicine or pediatric pulmonary medicine. Unlike *Boice*, Dr. Goldenring has admitted

that it is not appropriate for general pediatricians to manage critically ill patients in a PICU setting, so it cannot be established that the standard of care for managing such patients is the same regardless of whether the patients are managed by a general pediatrician or a pediatric critical care physician. Because the general rule applies in this case, Dr. Goldenring is not qualified to testify as an expert against Dr. Witte. A review of Dr. Goldenring's specific opinions confirms this conclusion.

(i) Necessity of CT Scan and Method of Ventilation

At its core, this case involves the following two medical decisions that were made by Dr. Witte: (1) to transport Derek for a CT scan; and (2) to use the Pulmonetic ventilator for the transport. While Plaintiff contends that Dr. Goldenring does not challenge Dr. Witte's decision making process, the record establishes that Dr. Goldenring has challenged both the necessity of obtaining a CT scan on the afternoon of November 26 and the selection of the Pulmonetic ventilator as opposed to hand bagging.

By his own admissions, Dr. Goldenring is not an expert in the medical issues that lead Dr. Witte to conclude that it was very critical to obtain a CT scan when it was performed. (R. at 843-848, 853.) A review of Dr. Goldenring's deposition testimony about ICPs and CPPs demonstrates that he is out of his depth when it comes to the neurological issues that drove Dr. Witte's decision to transport Derek for a CT scan. (R. at 843-847, 853.).

Similarly, Dr. Goldenring admits that he is not an expert in ventilation and has no experience using the Pulmonetic ventilator at issue in this case. (R. at 851-852.) Further,

Dr. Goldenring defers to a respiratory therapist as to whether a different type of ventilator could have been used. (R. at 851-853.) Significantly, both Dr. Witte and the respiratory therapist involved in the transport testified that no other ventilator could have provided the level of support needed by Derek. (R. at 791, 799, 812.) While Dr. Goldenring speculated that hand bagging would have been a viable alternative, he readily admits that was the "old way of doing" things and that he had to consult with another physician to determine if that method is still used. (R. at 838, 850-851, 861, 1352.)

While an otherwise qualified expert may not be precluded from testifying simply because he consulted with another expert, a physician who is not qualified to testify as an expert cannot become qualified by consulting with others. *See Dikeou v. Osborn*, 881 P.2d 943, 947 (Utah Ct. App. 1994) (affirming disqualification of expert who tried to become an expert on standard of care by reading and studying documents related to case). *But see State v. Clayton*, 646 P.2d 723, 725 (Utah 1982) (holding "once expert is qualified by the court, the witness may base his opinions on reports, writings or observations not in evidence which were made or compiled by others").

The record establishes that Dr. Goldenring is not qualified to offer expert opinions on either of the two primary medical decisions at issue in this case. In an effort to get around these deficiencies, Plaintiff argues that Dr. Goldenring is qualified to opine on the standard of care applicable to the entire team of health care providers involved in Derek's care even though Dr. Goldenring is not qualified to testify as to the standard of care for any single member of that team. Plaintiff's argument is not supported by any legal

authority, is illogical and fails to take into account the fact that the University Defendants are legally responsible for only one member of that team, Dr. Witte.

(ii) Consultation

Dr. Goldenring specifically opines that Dr. Witte breached a team standard of care by failing to consult with a neurosurgeon before transporting Derek. While a general pediatrician such as Dr. Goldenring would undoubtedly need to consult with a critical care physician or neurosurgeon about the need for a CT scan on a patient like Derek, Dr. Goldenring cannot competently say when a pediatric critical care physician must obtain consultation from another specialist without first establishing an understanding of the scope of a critical care physician's training and experience in managing PICU patients.

As demonstrated by Dr. Goldenring's inability to assess the severity and significance of the brain injury that Dr. Witte was treating in this case, Dr. Goldenring has no knowledge of the limits of Dr. Witte's ability to treat such injuries without consulting another specialist. Further, with respect to Derek's pulmonary issues, Dr. Witte is the expert since she is a pediatric pulmonary specialist. A neurosurgeon would go to Dr. Witte concerning pulmonary issues.

(iii) Adherence to Alleged "Hospital Rules"

Dr. Goldenring also testifies that Dr. Witte breached team standards of care established through the CTM process. Because the record establishes that use of the Pulmonetic ventilator was outside the scope of the CTM process, facts regarding that process or alleged standards of care established by the CTM committee are irrelevant.

Even if the CTM process was relevant, Dr. Goldenring is not qualified to testify as an expert on standards of care allegedly created through the CTM process.

While Dr. Goldenring claims to have 10 years of experience in administrative medicine, when probed about the details of that experience, Dr. Goldenring revealed the following: (1) he has never served as a hospital administrator; (2) he has never participated in a CTM-like process of evaluating new equipment for purchase; (3) he has never written protocols for a CTM-like process; and (4) his administrative experience primarily involves maintaining HMO and IPA contracts with health care providers and ensuring that those providers follow rules established by the HMOs and IPAs that employ Dr. Goldenring. (R. at 1928-1930, 1933, 2151.)

The record fails to establish that Dr. Goldenring has any experience that would qualify him as an expert on the issues of whether decisions made by the CTM committee have any application outside the CTM process or whether alleged rules established through the CTM process constitute standards of care for Dr. Witte.

(iv) Informed Consent

Dr. Goldenring also opines that Dr. Witte breached the standard of care by failing to advise Derek's father about the risk of ventilator malfunction. (R. at 1322-1323.) Dr. Goldenring is admittedly not an expert in ventilators and therefore has no basis to authoritatively opine on the issue of what medical information about the ventilator, if

any, should have been disclosed to Derek's father.[2] Further, the record fails to establish that Dr. Goldenring has any experience obtaining informed consent for transports in a PICU setting. Finally, the record establishes that informed consent was obtained. The risk of transport was discussed, and Derek's father responded by stating, "Do what you can to save my son." (R. at 1889, 1907.) While Plaintiff may dispute the adequacy of the information provided, Dr. Goldenring simply isn't qualified to testify as an expert on that issue. Plaintiff additionally argues that Dr. Witte breached a standard of care by failing to advise Derek's father about the status of the CTM process. That argument is addressed below.

III. DR. GOLDENRING'S OPINIONS DO NOT SATISFY THE RULE 702(B) REQUIREMENTS

Rule 702(b) requires expert opinions to be (i) reliable; (ii) based on sufficient facts or data; and (iii) reliably applied to the facts of the case. Utah R. Evid. 702(b). Expert testimony "draws conclusions based on theories, tests and experience, and its utility turns in part on how closely the conclusion is connected to the underlying data—whether it is but a short step from data to conclusion or a long inferential leap. The closer the connection, the better the fit." Christopher B. Meller & Laird C. Kirkpatrick, *Federal Evidence*, Vol. 3, § 7:10 (3rd ed. 2007); *see also McDowell v. Brown*, 392 F.3d 1283, 1299 (11th Cir. 2004).

[2] The University's critical care expert testified that Dr. Witte was not required to obtain informed consent for use of the Pulmonetic ventilator. Dr. Schexnayder specifically testified that the Pulmonetic ventilator is like any other piece of FDA approved medical equipment that is routinely used to treat hospital patients without informed consent.

When an expert's conclusion "simply does not follow from the incomplete data he examined, the court is free to determine that an impermissible analytical gap exists between the premises and conclusion." *North v. Ford Motor Co.*, 505 F. Supp. 2d 1113, 1119 (D. Utah 2007) (granting motion in limine to exclude expert testimony of psychologist who prepared damage reports). Rule 702 does not require a trial court "to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert." *Domingo v. T.K., M.D.*, 289 F.3d 600, 607 (9th Cir. 2002).

Here, Dr. Goldenring's opinions do not follow from the facts contained in the record. Some of the alleged facts relied on by Dr. Goldenring are inaccurately stated by him. In addition, there are analytical gaps between the alleged facts and the conclusions Dr. Goldenring draws from them.

A. Necessity of CT Scan

Dr. Goldenring's criticism of the timing of Dr. Witte's decision to transport Derek is based on an inaccurate interpretation of Dr. Witte's testimony about what she would have done if the Pulmonetic ventilator had not been available. In answering a hypothetical question, Dr. Witte did not state or imply that it would have been appropriate to defer the CT scan. (R. at 790.) While Dr. Witte acknowledges that she could not have transported Derek without the Pulmonetic ventilator, Dr. Witte clearly testified that she thought it was "very critical" that a CT scan be obtained in the afternoon of November 26. (R. at 795). Thus, Dr. Goldenring's opinion simply does not follow from the evidence he relies on in support of that opinion.

B. Consultation and Method of Ventilation

Dr. Goldenring relies on distant, prior experience rounding on his general pediatric patients in the PICU as a basis for his opinion that Dr. Witte should have consulted other health care providers before transporting Derek. As already discussed, Dr. Goldenring's past experience as a general pediatrician does not establish a reliable basis for opining on the standard of care for a pediatric critical care physician who is responsible for managing critically ill patients in a PICU setting.

Dr. Goldenring also bases his opinion on an assumption that the providers at PCMC followed a team approach to providing treatment and care. (R. at 854, 1363.) Expert testimony may not be based on a "mere guess, speculation or conjecture." *Thurston v. Worker's Comp. Fund of Utah*, 2003 UT App 438, ¶ 20, 83 P.3d 391; *see also Nelson v. Safeco Ins., Co.*, 396 F. Supp. 2d 1274, 1278 (D. Utah 2005) (A "district court must exclude expert testimony that is no more than subjective belief or unsupported speculation").

Dr. Goldenring's assumption of how Dr. Witte and the other providers at PCMC interact with each other does not form a reliable basis for his expert opinions. Furthermore, Dr. Goldenring's assumption does not necessarily comport with the facts. Inanimate teams do not practice medicine or provide care; individual providers must do that within the scope of their respective licenses, training and experience. While Dr. Witte obtained input from other providers, she retained ultimate responsibility for making decisions about Derek's treatment and care.

Finally, Dr. Goldenring's opinion that Dr. Witte failed to consult other members of the multidisciplinary team is simply inaccurate. Many other physicians were consulted during Derek's hospitalization, including neurosurgery. Moreover, Dr. Witte specifically obtained input from the PICU fellow, PICU residents, respiratory therapists and PICU nurses before making the decision to transport Derek for a CT scan. (R. at 793-794.) As previously noted, Dr. Goldenring is not qualified to criticize Dr. Witte for not obtaining specific consults about specific issues. While Dr. Witte did not consult with a neurosurgeon about the transport, the facts establish that the neurosurgery service had already ordered a CT scan. (R. at 795.) Thus, Dr. Goldenring's opinion on consultation is not reliably applied to the facts of the case.

Dr. Goldenring's reliance on AARC guidelines in support of his opinions on consultation and the viability of hand bagging as an alternative method of ventilation is faulty for several reasons. First, the AARC is not an organization of physicians, and there is no authority supporting Dr. Goldenring's conclusion that guidelines promulgated by the AARC apply to physicians or that they set the standard of care for a pediatric critical care physician such as Dr. Witte. *See* http:// www.aarc.org/member_services ("[T]he AARC is the only professional society for respiratory therapists in hospitals and with home care companies, managers of respiratory and cardiopulmonary services, and educators who provide respiratory care training.").

Second, even if the record established that AARC guidelines do set the standard of care for Dr. Witte, the cited guidelines do not support Dr. Goldenring's conclusions. The

AARC guideline Dr. Goldenring relies on in support his consultation opinion reads "the necessity and safety for a transport should be assessed by the multidisciplinary team of health care providers, e.g. respiratory therapist, physician, nurse." (R. at 3143.) Significantly, this guideline does not require the patient's attending critical care physician to consult with a neurosurgeon or any other type of physician.

Likewise, the AARC guidelines do not support Dr. Goldenring's conclusion that hand bagging would have been a viable alternative method of ventilation. The AARC guideline Dr. Goldenring relies on in support of that opinion lists contraindications for a transport, including the inability to provide adequate oxygenation during transport either by manual ventilation, portable ventilator or standard ICU ventilator. (R. at 3142.) Even if applicable, that guideline is a general statement and does not support a conclusion that hand bagging Derek would have been a viable alternative in this particular case.

Even Dr. Goldenring was less than sure about his reliance on the AARC guidelines. When asked about the authoritativeness of those guidelines in establishing the standard of care, he was quick to state that while he thinks they are relevant, he "will rarely say that a guideline on its own absolutely determines everything because there's also case-by-case issues." (R. at 1342.) For all of these reasons, Dr. Goldenring's reliance on AARC guidelines violates Rule 702(b).

C. Adherence to "Hospital Rules" and Informed Consent

Dr. Goldenring's opinions that Dr. Witte breached the standard of care by using the Pulmonetic ventilator on a critically ill patient and by failing to obtain informed

consent are based on a faulty conclusion that the CTM process established standards of care that govern both the CTM process and a physician's use of ventilators outside that process. Dr. Goldenring's opinions do not flow from the facts contained in the record. First, the record establishes that the Pulmonetic ventilator was used outside the scope of CTM process in this case. Thus, facts relating to the CTM process are irrelevant and cannot form a reliable basis for standard of care opinions. Second, there is nothing in the record to support the conclusion that the CTM process established the standard of care for Dr. Witte or otherwise restricted her ability to practice medicine by using a ventilator that is both approved by the FDA for use in a PICU setting and used by pediatric critical care physicians in other hospitals to transport critically ill patients for a CT scan.

There is ample support in the record to support the conclusion that the CTM process does not establish the standard of care. One, the process is not mandatory. (R. at 1982, 2016.) Two, the documented purpose of the process is to create an organized system for managing the "equipment life cycle," which is distinguishable from an organization whose stated purpose is to set standards of care for health care providers. (R. at 3232.) Three, the CTM committee included professionals with no medical training or experience such as a clinical engineer and a finance manager. (R. at 3241.) Dr. Goldenring ignores these facts and simply concludes that the CTM process established a standard of care that should have been followed by Dr. Witte. That conclusion simply does not follow from the facts contained in the record.

Even if the CTM process did have authority to establish standards of care for critical care physicians such as Dr. Witte, Dr. Goldenring has drawn inaccurate conclusions about the "hospital rules" purportedly established by the CTM committee. The record does not reflect that Dr. Goldenring reviewed any CTM committee documents, so any opinions he offers about rules purportedly established through the CTM process are inherently unreliable. Further, the record does not support Dr. Goldenring's conclusion that the CTM committee precluded use of the Pulmonetic ventilator on critically ill patients such as Derek. The CTM committee's notes do not reflect a decision being made that the ventilator could not be used on critically ill patients. (R. at 3171-3174.) Moreover, Dr. Witte's understanding of the patient population to be selected for the clinical evaluations does not support Dr. Goldenring's opinion that the ventilator could not be used on critically ill patients. The fact that the CTM committee may have decided to conduct the clinical evaluations using the patient population on whom the ventilator was most likely to be used in Life Flight transports does not mean that the ventilator is unsafe for use on all other patient populations, including critically ill patients.

In summary, any decisions made by the CTM committee about how it would conduct its business of evaluating ventilators for purchase did not preclude Dr. Witte from using whatever FDA approved medical devices were at her disposal to treat Derek. Simply put, there is no evidence in the record to suggest that the CTM committee had any

authority to regulate Dr. Witte's practice of medicine or that the committee made any attempt to impose restrictions on Dr. Witte's treatment decisions.

The facts contained in the record also fail to support Dr. Goldenring's conclusion that a "hospital rule" required informed consent for use of the Pulmonetic ventilator. While the record establishes that the CTM committee discussed the need to have a separate discussion with PCMC's risk management department about the need for parental consent, the record does not reflect that parental consent was ultimately required. To the contrary, the record reflects that two members of the CTM committee, including Dr. Witte, did not believe that informed consent was required. (R. at 789, 1910, 3174.) Furthermore, the record establishes that the ventilator was used outside the scope of the CTM process in this case. Accordingly, any decision made about obtaining informed consent for purposes of the CTM process would not apply outside that process.

Similarly, the PCMC handout titled "Let's Talk About . . . patient and family rights" does not support Dr. Goldenring's opinion that informed consent was required for use of the ventilator. The handout does not purport to establish a standard of care for informed consent and also does not address what specific information must be shared with a patient's parents. Rather, the publication generally advises parents that they have the right to be informed about their child's diagnosis, treatment and known outcomes and that they have the right to participate in their child's plan of care in collaboration with the child's physician. (R. at 3146.) The record establishes that all of those things were done in this case. Even if the handout established the standard of care for informed consent, it

does not require informed consent for use of FDA approved medical devices. Accordingly, Dr. Goldenring's reliance on the handout is misplaced and unreliable.

Finally, Dr. Goldenring's opinion that Derek's father may have had difficulty understanding information communicated to him in English is unsupported by the record. Even Dr. Goldenring acknowledged as much. (R. at 855, 1322.) In summary, Dr. Goldenring's opinions regarding adherence to alleged hospital rules established through the CTM process do not follow from the facts. Accordingly, Dr. Goldenring's opinion that Dr. Witte breached the standard of care by failing to comply with such rules fails to satisfy the Rule 702(b) requirements.

IV. DR. GOLDENRING'S CAUSATION OPINIONS ARE SPECULATIVE AND FAIL TO SATISFY RULE 702(B)

Dr. Goldenring's opinion that use of the Pulmonetic ventilator was the cause of Derek's death was properly rejected by the trial court because it is both speculative and fails to satisfy the Rule 702(b) requirements. Causation must be affirmatively established through non-speculative evidence. *Fox v. Brigham Young Univ.*, 2007 UT App 406, ¶¶ 22-23, 176 P.3d 446. An expert whose opinions are speculative should not be allowed to testify. *Stevenson v. Goodson*, 924 P.2d 339, 347 (Utah 1996); *George v. LDS Hosp.*, 797 P.2d 1117, 1122 (Utah Ct. App. 1990).

When questioned about his causation opinion, Dr. Goldenring agreed that it would be speculative to say what Derek's outcome would have been absent the ventilator failure. (R. at 856.) When specifically asked whether he could give an opinion within a reasonable degree of medical certainty as to whether Derek would have survived absent

the ventilator failure, Dr. Goldenring testified, "He certainly had a chance of survival. I'm not sure that I can give you a number. I'm not sure that I have enough intensive care experience to do that." (R. at 856.)

The University Defendants agree with Dr. Goldenring that any conclusion about Derek's outcome absent the ventilator failure is speculative. He was critically ill upon admission to PCMC, and his condition deteriorated to the point that Dr. Witte thought he could go into cardiopulmonary arrest at any time before the transport at issue occurred. Further, Derek's ICPs and CPPs were not conducive to a good neurologic outcome, and Dr. Witte was concerned that Derek might die if the CT scan was not done. Absent the ventilator malfunction, Derek's outcome was still far from certain.

Even without Dr. Goldenring's admission that his causation opinion is speculative, the opinion was properly stricken because Dr. Goldenring cannot quantify the chance of survival he claims Derek lost as a result of ventilator malfunction. While this Court has previously held that testimony establishing an increased chance of survival to a reasonable degree of medical certainty may establish causation, the Court did not address the issue of whether the chance of survival must reach a certain threshold. *George*, 797 P.2d at 1122; *see also Andersen v. Brigham Young Univ.*, 879 F. Supp. 1124, 1129 (D. Utah 1995).

It appears that many jurisdictions hold that no recovery is allowed for loss of chance of survival if the patient had less than a fifty percent chance of obtaining a more favorable outcome absent the alleged malpractice. Sandra J. Smith & Ugo Colella, *Lost*

Chance Recovery and the Folly of Expanding Medical Malpractice Liability, 27 Tort & Ins. L.J. 615, 615-16 (1992). Other jurisdictions have allowed recovery even when the patient had less than a fifty percent chance of survival. *See Kilpatrick v. Bryant*, 868 S.W.2d 594, 600-601 (Tenn. 1993) .

This Court need not decide which approach should be followed in Utah because no matter which approach is chosen, there must be some quantification of the lost chance of survival. Courts in other jurisdictions require that the lost chance of survival be quantified. In one such case, the court concluded as follows:

> Here, no expert will state with reasonable probability and precision what the chances were that the surgery would have worked, much less offer any opinion as to the percentage by which Defendant's alleged negligence reduced the chance of success. The percentages are vital because they form the basis for any damage calculation by the jury. Without them, the jury would be left to speculation. . . . Thus, regardless of the court's willingness to apply the increased risk doctrine . . . Plaintiff's proof falls short.

Kern v. Alfred I. Dupont Inst. of the Nemours Found., 2004 WL 2191036 at *4 (Del. July 30, 2004) (granting summary judgment in favor of the defendant) (copy included in addendum); *see also Foley v. Fletcher*, 836 N.E.2d 667, 677 (Ill. Ct. App. 2005) (overturning jury award because plaintiff's experts could not quantify risk of future injury as a result of the alleged malpractice); *Wright v. St. Mary's Med. Ctr. of Evansville, Inc.*, 59 F. Supp. 2d 794, 801 n.2 (S.D. Ind. 1999) (citing treatise on damages for proposition that value of loss of chance must be "fairly measurable").

Quantification of risk has also been addressed by the Utah Supreme Court in a different context. In a personal injury action, the Utah Supreme Court relied on the fact that an expert quantified the plaintiff's risk of future surgery at fifteen percent in holding that the increased risk was not speculative and that plaintiff could be awarded damages for that increased risk even though it was less than fifty percent. *Brown v. Johnson*, 24 Utah 2d 388, 472 P.2d 942, 945 (1970). Regardless of whether Utah's appellate courts choose to enforce a minimum threshold requirement for loss of chance, experts still must quantify the lost chance so that jurors are not left to sheer speculation in awarding damages. Dr. Goldenring's inability to quantify the alleged lost chance of survival in this case renders his causation opinion speculative.

Dr. Goldenring's causation opinion also fails to satisfy the Rule 702(b) requirements. The alleged basis for Dr. Goldenring's causation opinion is testimony from Dr. Witte. Dr. Witte's testimony does not support Dr. Goldenring's opinion that the ventilator failure caused Derek's death. Rather, she testified that while use of the ventilator probably influenced the timing of Derek's death, she could not say that the ventilator caused his death. (R. at 1892.) Thus, Dr. Goldenring's opinion is based on an incorrect interpretation of Dr. Witte's testimony and is therefore unreliable.

V. EXPERT TESTIMONY IS REQUIRED

To establish a prima facie case of medical malpractice against the Defendants, Plaintiff must prove the following elements: (1) the standard of care; (2) that the standard of care was breached; (3) that the Defendants' breach proximately caused injury;

and (4) damages. *Jensen v. IHC Hosp., Inc.*, 2003 UT 51, ¶ 96, 82 P.3d 1076. "A plaintiff's failure to present evidence that, if believed by the trier of fact, would establish any one of the [required elements] of a prima facie case justifies a grant of summary judgment to the defendant." *Dikeou v. Osborn*, 881 P.2d 943, 946 (Utah Ct. App. 1994); *see also Jensen v. IHC Hosp., Inc.*, 944 P.2d 327, 339 (Utah 1997) (stating that once the party moving for summary judgment has challenged the existence of one of the elements of the cause of action, the nonmoving party bears the burden of providing some evidence in support of the essential elements of his or her claim).

A plaintiff generally must present expert testimony to establish the standard of care, breach of that standard and causation. *Kim v. Anderson*, 610 P.2d 1270, 1271 (Utah 1980); *Reeves v. Geigy Pharm., Inc.*, 764 P.2d 636, 640 (Utah Ct. App. 1988); *Hoopiiaina v. Intermountain Health Care*, 740 P.2d 270, 271 (Utah Ct. App. 1987). Expert testimony is required to support malpractice claims against health care providers because the complex nature of a health care provider's services is outside the understanding and experience of lay persons. *Nixdorf v. Hicken*, 612 P.2d 348, 352 (Utah 1980); *Chadwick v. Nielsen*, 763 P.2d 817, 821 (Utah Ct. App. 1988); *Preston & Chambers, P.C. v. Koller*, 943 P.2d 260, 263 (Utah Ct. App. 1997).

Under the Utah Health Care Malpractice Act, informed consent is presumed. Utah Code Ann. § 78B-3-406 (2008). To rebut that presumption, a plaintiff must show that the treatment at issue carried "substantial and significant risk of causing the patient serious harm" and that the patient was not advised of such risks. *Id.* The Utah Supreme Court

has concluded that expert testimony is required to support a claim for failure to obtain informed consent "to prove the materiality of the risk involved." *Chadwick*, 763 P.2d 817, 821 n.4.

A. Testimony from Derek's Treating Health Care Providers Does Not Establish Plaintiff's Causes of Action

Plaintiff argues that expert testimony provided by individuals other than Dr. Goldenring establishes Plaintiff's causes of action for negligence and failure to obtain informed consent. Significantly, Plaintiff fails to cite any testimony from other witnesses establishing an essential element of Plaintiff's causes of action, causation. Further, the testimony that is cited by Plaintiff on the standard of care is inaccurately summarized. Finally, some of the cited testimony fails to establish a duty on the part of the University Defendants.

For example, Plaintiff cites testimony from the CTM committee chairperson, Tammy Bleak, R.N., and represents that she acknowledged having a duty to ensure the reliability of the Pulmonetic ventilator before allowing it to be used on a patient. A review of the record reveals that Plaintiff's summary of Nurse Bleak's testimony is inaccurate. Nurse Bleak expressly denied having any quality assurance responsibility for new equipment and further testified that new equipment received from the manufacturer is considered to be "worthy to be used" on patients after PCMC's clinical engineering department performs a basic electrical safety inspection. (R. at 1242.) Even if Nurse Bleak's testimony did establish a breach of duty on her part, it does not establish a breach of duty by Dr. Witte or impose any liability against her employer, the University.

Plaintiff also points to purported testimony from unspecified individuals that "hospital rules," i.e. the CTM process and patient rights handout, prohibited use of the Pulmonetic ventilator on critically ill patients and also required parental consent. Even if the CTM process and patient rights handout were relevant and authoritative sources for establishing the standard of care for Dr. Witte, the record fails to establish that Dr. Witte breached any duty that is purportedly imposed by either the CTM committee or the patient rights handout, as argued above.

B. The Common Knowledge Exception Does Not Apply

Utah courts have recognized a limited exception to the general rule requiring expert testimony to support a medical malpractice case. "[E]xpert testimony is unnecessary to establish the standard of care owed the plaintiff where the propriety of the treatment received is within the common knowledge and experience of the layman." *Nixdorf v. Hicken*, 612 P.2d 348, 352 (Utah 1980). This exception is only applicable in the most blatant malpractice cases. *Nixdorf* is a good example of such a case. In *Nixdorf*, the defendant surgeon left a surgical needle inside the plaintiff. *Id.* at 351. The Utah Supreme Court held that expert testimony was unnecessary to establish negligence because "it would seem as a matter of common sense that scientific opinion could throw little light on the subject." *Id.* at 352 (citation omitted).

Plaintiff briefly argues that medical knowledge is not necessary to understand this case. This argument is without merit. Lay persons have no experience managing critically ill pediatric patients and therefore have no basis for knowing whether Derek's

medical condition required a CT scan or whether the Pulmonetic ventilator was the only viable option for ventilation during the transport. Similarly, lay persons have no experience in hospital administration and therefore cannot independently determine whether an FDA approved ventilator could be used outside the scope of the CTM process or whether any protocols established through the CTM process have any application outside that process. Lay persons also do not have the knowledge and experience to know what risks were material to the transport and should have been discussed with Derek's father. Finally, even if lay persons could understand the standard of care issues without the assistance of expert testimony, they have no ability to independently determine if the ventilator malfunction caused Derek's death.

C. Plaintiff's Informed Consent Claim Fails as a Matter of Law

Regardless of whether the trial court properly granted the motion to strike Dr. Goldenring, summary judgment was properly granted with respect to Plaintiff's claim for failure to obtain informed consent. While courts have not addressed the issue of whether the status of an in-house equipment purchasing evaluation must be disclosed to patients, courts in other jurisdictions have held that the FDA status of a medical device need not be disclosed. Patients in several cases brought suit against physicians and alleged that they improperly failed to disclose that pedicle screws implanted in the patients' pedicles during spinal fusion surgery had not been approved by the FDA for that use. *See, e.g., Blazoski v. Cook*, 787 A.2d 910, 913 (N.J. Sup Ct. App. Div. 2003); *Southard v. Temple Univ. Hosp.*, 781 A.2d 101, 102 (Pa. 2001).

The screws at issue in *Blazoski* and *Southard* were classified by the FDA as "experimental devices of unproven safety and efficacy." *Blazoski*, 787 A.2d at 914. While they were approved by the FDA for implantation in the sacrum, they were not approved for implantation in pedicles. *Id.* The courts in those cases recognized that the FDA does not regulate the practice of medicine. *Southard* 781 A.2d at 104. The courts held, as a matter of law, that physicians are not required to advise patients of the FDA status of medical devices. *Id.* at 108; *Blazoski*, 787 A.2d at 913. In support of these holdings, the courts emphasized that the FDA status of a medical device "does not speak directly to the medical issues surrounding a particular surgery." *Id.* at 919. Rather, the FDA's classification of pedicle screws as experimental and unproven for safety are administrative terms used for regulatory purposes and are not risks of the surgical procedure itself. *Southard*, 781 A.2d at 105.

Here, the Pulmonetic ventilator was approved by the FDA for the very use to which it was put by Dr. Witte. The fact that the CTM process for transport ventilators was incomplete does not speak to the medical risks and benefits of either a transport for a CT scan or use of the Pulmonetic ventilator during the transport. Therefore, as a matter of law, Dr. Witte had no duty to disclose anything about the CTM process to Derek's father, especially since Dr. Witte's use of the ventilator was outside the scope of the CTM process.

VI. THE FACTS DO NOT SUPPORT PLAINTIFF'S CLAIMS FOR INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS AND PUNITIVE DAMAGES

The University joins PCMC's arguments concerning summary judgment in favor of the Defendants on Plaintiff's cause of action for intentional infliction of emotional distress and claim for punitive damages. Additionally, the University Defendants emphasize that Dr. Witte thought there was a high likelihood that Derek would die if a CT scan was not completed in the afternoon of November 26. Dr. Witte made a medically supported decision to transport Derek to the CT scanner using the Pulmonetic ventilator, which was the only available ventilator that could provide the necessary level of support. Derek's father was advised that a CT scan was needed and that there was risk associated with the transport. In response, he urged the providers to do what they could to save his son's life.

The Pulmonetic ventilator used to transport Derek was approved by the FDA for use in transporting PICU patients and has been used by critical care physicians at other hospitals for that purpose. Unfortunately, the ventilator lost power as a result of a mechanical problem that could not have been recognized by Dr. Witte or any of the other health care providers. Even without the ventilator failure, Derek's prognosis was very uncertain. These are not the kind of extreme and outrageous facts that support a cause of action for intentional infliction of emotional distress or a claim for punitive damages.

Even if the facts in this case did warrant punitive damages, the trial court correctly ruled that the Governmental Immunity Act of Utah precludes an award of punitive

damages against the University Defendants. *See* Utah Code Ann. § 63G-7-603(1)(a) (2008). Both the Utah Supreme Court and the Tenth Circuit Court of Appeals have recognized and applied this statutory bar on punitive damages. *See Youren v. Tintic Sch. Dist.*, 343 F.3d 1296, 1307 (10th Cir. 2003); *Lyon v. Burton*, 2000 UT 55, ¶ 66, 5 P.3d 616, 634. In *Lyon*, the Utah Supreme Court stated that punitive damages against governmental entities are "barred outright." *Id.*

In addition to suing the State of Utah, Plaintiffs have brought suit against the University of Utah and the University of Utah Hospitals and Clinics. All three are classified as governmental entities entitled to full protection under the Act. *See* Utah Code Ann. § 63G-7-102(9) (2008) (classifying both universities and hospitals as the State of Utah); *cf. Nunez v. Albo*, 2002 UT App 247, ¶ 21 n.1, 53 P.3d 2 (recognizing that the University of Utah School of Medicine is a governmental entity under the Act); *Carter v. Milford Valley Mem'l Hosp.*, 2000 UT App 21, ¶ 14, 996 P.2d 1076 (recognizing that the Act is implicated when suit is brought against a hospital that is owned and operated by a governmental entity). As a matter of law, the University Defendants may not be held liable for punitive damages. Accordingly, summary judgment was appropriately granted in favor of the University Defendants with respect to punitive damages.

CONCLUSION

Based on the foregoing facts and legal authority, the trial court's rulings striking Dr. Goldenring and granting summary judgment in favor of the University Defendants with respect to all of Plaintiff's causes of action and his claim for punitive damages

should be affirmed. The Court should exercise its discretion to award costs to the University Defendants pursuant to Rule 34(b) of the Utah Rules of Appellate Procedure.

DATED this 24 day of April, 2009.

SNOW, CHRISTENSEN & MARTINEAU

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CERTIFICATE OF SERVICE

I hereby certify that two true and correct copies of the foregoing **BRIEF OF APPELLEES UNIVERSITY OF UTAH HOSPITALS AND CLINICS, UNIVERSITY OF UTAH AND STATE OF UTAH** were served by U.S. Mail this 24 day of April, 2009 on the following:

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ADDENDUM

1. *Kern v. Alfred I. Dupont Inst. of the Nemours Found.*, 2004 WL 2191036 at *4 (Del. July 30, 2004)

c

Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Delaware.
Diane KERN, as next friend of Samantha Kern, Plaintiff,
v.
THE ALFRED I. DUPONT INSTITUTE OF THE NEMOURS FOUNDATION a/k/a A.I. Dupont Hospital, Defendant.
No. Civ.A.02C05001FSS.

Preliminary Ruling Feb. 26, 2004.
Submitted April 9, 2004.
Decided July 30, 2004.

Upon Defendant's Motion for Summary Judgment-Granted.
Kenneth M. Roseman, Ciconte Roseman & Wasserman, Wilmington, Delaware, for Plaintiff.

Joseph S. Naylor, Pepper Hamilton, LLP, Wilmington, Delaware, for Defendant.

OPINION AND ORDER

SILVERMAN, J.

***1** This medical negligence case involves a 2-month old child who underwent throat surgery to widen her trachea. Post-operative complications developed and the surgery failed. Plaintiff has sued the hospital, alleging that nurses negligently monitored an intravenous tube inserted in the child's head.

Plaintiff tacitly acknowledges that the surgery was dicey. Even so, Plaintiff contends that Defendant's post-operative negligence increased the risk that the throat surgery would fail. Furthermore, Plaintiff seeks to call the surgeon to testify not only about the surgery and other treatment she rendered, but also to serve as Plaintiff's medical expert on the standard of post-operative care and causation. Plaintiff, however, has not retained the treating physician, the surgeon, as an expert. If called, the treating physician would testify as a fact witness about the care she rendered, but she does not agree to offer expert opinions about the hospital's treatment. Moreover, if forced to testify as an expert, the treating physician would not opine that negligence by Defendant proximately caused injury to Plaintiff.

The court, therefore, must decide two questions: First, will the "increased risk doctrine" be expanded to cover Plaintiff's claim? Second, can the Plaintiff force the child's treating physician to testify as an expert on the hospital's standard of care and causation? The court also will address whether the treating physician's opinions adequately support Plaintiff's cause of action.

I.

The parties submitted a pre-trial stipulation including the facts below. On September 8, 2000, Samantha Kern was born at Christiana Hospital in Newark, Delaware. She was eleven weeks premature, weighing only two pounds, eight ounces. Samantha was unable to breathe on her own, and an endotracheal tube was inserted into her throat to improve airflow to her lungs.

On November 1, 2000, Samantha transferred from Christiana Hospital to the Alfred I. duPont Hospital for Children in Wilmington. At the duPont Hospital, Ellen Deutsch, M.D., evaluated Samantha's airway and diagnosed her with subglottic stenosis, or a narrowing of the airway above the vocal cords. Dr. Deutsch works for the hospital as a pediatric otolaryngologist.

Dr. Deutsch performed a cricoid split on Samantha

on November 2, 2000 This involved splitting the main cartilage in Samantha's trachea and inserting a graft from her hyoid bone in the incision The procedure was meant to widen Samantha's airway to allow unassisted breathing Following the cricoid split, Samantha was sedated and paralyzed per Dr Deutsch's post-operative instructions

While Samantha was still sedated and paralyzed on November 8, 2000, a nurse discovered that an intravenous line in Samantha's scalp had leaked into the tissue surrounding the vein in which it was inserted Instead of going into the vein, I V fluid was collecting under the skin near the child's head and neck, causing swelling The I V was removed, and Dr Deutsch placed a drain in an incision she made in Samantha's neck during the cricoid split Over the next 24 hours, the I V fluid drained and the swelling subsided

***2** On November 9, 10 and 13, 2000, Samantha's endotracheal tube was removed to determine whether she could breathe autonomously Each time, she experienced difficulty breathing and the endotracheal tube was replaced On November 13, Dr Deutsch performed a tracheotomy on Samantha, a procedure where the trachea is cut and a tube is inserted into the trachea so that the patient breathes directly through the tube Samantha will need the help of a tracheotomy tube to breathe for years into the future, at the least, and possibly for the rest of her life

Plaintiff argues that Samantha suffered two distinct injuries from the I V leak the resulting swelling and draining procedure were painful, and the leak caused spontaneous movement of Samantha's neck The swelling and movement increased the risk to an unknown extent, that the cricoid split would fail Although Plaintiff has not hired her as an expert, Plaintiff contends that Dr Deutsch, as treating physician, is available and the perfect witness to opine about Defendant's alleged negligence

Defendant counters that Plaintiff's proof fails in several ways Dr Deutsch, who is employed by Defendant, cannot be compelled to offer opinions against her will Therefore, Plaintiff has failed to identify an expert to establish Defendant's negligence Delaware's medical negligence statute, as presented below, requires medical expert testimony on standard of care and causation In addition, were she to testify, Dr Deutsch would not adequately support Plaintiff's "increased risk" claim While she would allow that any negligence by Defendant *could* have increased the risk that the surgery would fail, Dr Deutsch would not hazard a guess as to the specific percent by which the risk of failure was increased, much less that any negligence probably caused the failure

II

Procedurally, on May 1, 2002, Plaintiff filed a complaint for alleged injuries to her daughter Defendant answered on June 3, 2002 Defendant moved for summary judgment on November 26, 2003, and oral argument was held on February 5, 2004 The court announced this decision, without elaboration, at the pre-trial conference on February 26, 2004 Plaintiff conceded that in light of the court's decision, Plaintiff had no medical expert Furthermore, she declined to attempt to find one Accordingly, it is undisputed that the court's and Plaintiff's decisions mean that this case is over This opinion explains and finalizes the court's informal, February 26, 2004 ruling

III

Summary judgment is proper where there are no genuine issues of material fact, thus entitling the moving party to judgment as a matter of law [FN1] A court deciding a summary judgment motion must identify disputed factual issues whose resolution is necessary to decide the case but not to decide the issues [FN2] As mentioned for present purposes the facts are not in dispute The court, therefore, must apply the undisputed facts to the law, as the court finds the law to be, and in that way decide the mo-

tion.

FN1. *Johnson v. Bowman,* 1997 WL 719354, at *1 (Del.Super.Ct.) (citing *Merrill v. Crothall-American, Inc.,* 606 A.2d 96, 99-100 (Del.1992)).

FN2. *Merrill,* 606 A.2d at 99.

IV.

A. Increased Risk Doctrine

***3** As mentioned, there are two issues here. First, Plaintiff argues the "increased risk doctrine." Essentially, Plaintiff's stance is:

> The I.V. infiltrate caused swelling and spontaneous movement of Samantha's neck. The swelling and spontaneous movement caused an *increased risk* that the cricoid split [would] fail and that Samantha was at an increased risk of further injury and damages.[FN3]

FN3. Plaintiff's Answering Brief, at 4.

Plaintiff further says:

> [T]he sworn testimony and the statement of Dr. Deutsch could lead to a conclusion that the swelling and neck movement caused by the I.V. infiltrate increased the risk that the cricoid split performed on Samantha would fail.[FN4]

FN4.Id., at 5.

Ten years ago, while answering certified questions in *United States v. Cumberbatch,*[FN5] the Supreme Court of Delaware introduced the "increased risk doctrine" to Delaware, in a footnote. *Cumberbatch* explains that "[t]he increased risk doctrine provides that a person may recover damages if the person's risk of suffering a negative medical condition is increased because of medical malpractice."[FN6] In *Cumberbatch,* actually a "lost chance" case, it was given that absent defendant's malpractice, the patient had a forty-five percent chance of surviving. But the malpractice had reduced the patient's chances to twenty-five percent. *Cumberbatch* rejected the "lost chance" claim, but only because the claim in *Cumberbatch* was for wrongful death. In dicta, *Cumberbatch* suggested that Delaware would adopt the then-emerging, "proportional approach" to compensation for loss of chance.

FN5. 647 A.2d 1098 (Del.1994).

FN6. *Id.* at 1100 n. 3.

A year after *Cumberbatch,* the other shoe fell. In another case presenting certified questions, *United States v. Anderson,*[FN7] Delaware's Supreme Court formally adopted the "increased risk of future harm" doctrine. *Anderson* involved a late diagnosed cancer. There, the patient's chance of avoiding recurrence of cancer dropped from 100 percent to 85 percent, due to the negligence. *Anderson* holds that the increased risk doctrine is recognized in Delaware, mentioning that "[t]he increased risk doctrine has been employed in cases involving late diagnoses which allowed cancer to spread ... [t]he doctrine has also been employed in cases involving skull fractures and resulting future susceptibility to meningitis."[FN8] Plaintiff relies entirely on *Anderson.*

FN7. 669 A.2d 73 (Del.1995).

FN8. *Id.* at 76 (citations omitted).

Cumberbatch and *Anderson* cite with approval the federal District Court for Delaware's *Cudone v. Gehret,*[FN9] which also involved a late diagnosed cancer. There, the medical negligence caused the plaintiff-patient's chance of recurrence to increase from 25-30% to 50-60%. *Cudone* held the increased risk doctrine applied. *Cudone,* however, also referred to dicta in *Shively v. Klein,*[FN10] which involved a loss of chance. *Shively* warned against using the loss of chance doctrine for other than its in-

tended purpose. *Cudone,* referring to *Shively,* explained:

> FN9. 821 F.Supp. 266 (D.Del.1993).
>
> FN10. 551 A.2d 41 (Del.1988).

> [T]he Court determined that the application of the concept sought by plaintiffs, i.e., one which relaxed the standard of causation, "would have been a drastic departure from the causation standards consistently applied in Delaware."[FN11]

> FN11. 821 F.Supp. at 269 (quoting *Shively,* 551 A.2d at 44).

***4** Other authorities also apply the increased risk doctrine.[FN12] One example is *Petriello v. Kalman,*[FN13] a Connecticut case cited with approval in *Anderson.* The patient, Ann Petriello, experienced a difficult pregnancy. A doctor, Roy E. Kalman, negligently perforated Petriello's uterus while performing a dilatation and curettage on her. A different doctor then had to resect Petriello's bowel in order to repair the damage. But because of resulting adhesions "there was between an 8 and 16 percent chance that [Petriello] would suffer a future bowel obstruction as a result of the bowel resection necessitated by [Dr. Kalman's] actions ."[FN14] The increased risk doctrine led to a damages award that was sustained on appeal.

> FN12. See generally *Edwards v. Family Practice Associates, Incorporated,* 798 A.2d 1059 (Del.Super.Ct.2002) (although called "loss of chance," increased risk doctrine applied where failure to diagnose stomach cancer hastened plaintiff's death); Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences,* 90 Yale L.J. 1353 (1981).
>
> FN13. 576 A.2d 474 (Conn.1990).
>
> FN14.*Id.* At 481.

Regardless of whether the increased risk or lost chance doctrines were applied or not, a common element of the cases presented above is that every plaintiff proffered expert opinion specifically quantifying the increased risk or loss of chance caused by the medical negligence. Here, no expert will state with reasonable probability and precision what the chances were that the surgery would have worked, much less offer any opinion as to the percentage by which Defendant's alleged negligence reduced the chance of success. The percentages are vital because they form the basis for any damages calculation by the jury. Without them, the jury would be left to speculation. Furthermore, it is unclear whether Plaintiff's current condition, using a tracheotomy tube, is permanent. Thus, regardless of the court's willingness to apply the increased risk doctrine and force the treating physician to testify, Plaintiff's proof falls short.

In passing, the court reiterates the concern in *Shively* about the relaxed, proportional causation standard's impact on Delaware's entrenched approach to proximate cause. Unlike Connecticut, Delaware is a so-called "but for" jurisdiction. Typically, if a defendant's negligence merely is a substantial factor in causing injury, a plaintiff cannot recover in Delaware. The increased risk doctrine seems to compromise that standard where a treatment's chance of success was less than fifty percent at the outset. In such a situation, can it be said that any negligence which further reduced plaintiff's chances was more than a substantial factor in causing injury? In other words, if a defendant's negligence indisputably increased the likelihood of failure, but the surgery probably was doomed anyway, can it be said that but for the negligence the surgery probably would have succeeded? Those are questions for another case because, as presented above, no one can quantify the harm, if any, caused by Defendant's alleged negligence here.

B. Expert Witness

Delaware law requires expert medical testimony in

medical negligence cases such as this one.[FN15] Instead of retaining an expert, Plaintiff merely would call Samantha's surgeon as her expert on the hospital's standard of care and causation. Plaintiff would question the treating physician about the throat surgery she performed and try to elicit the opinion that the I.V.'s placement violated the standard of care and caused the surgery to fail, which made the tracheotomy necessary.

> FN15.DEL.CODE ANN.tit. 18, § 6853 (1999)("No liability shall be based upon asserted negligence unless expert medical testimony is presented as to the alleged deviation from the applicable standard of care in the specific circumstances of the case and as to the causation of the alleged personal injury or death ...").

***5** The first problem is that the treating physician has little or no factual knowledge about Samantha's post-operative care. More importantly, the treating physician is employed by Defendant. She has not been offered as an expert for Defendant. Nor has she performed an "independent medical examination" at either party's request.[FN16]

> FN16. Cf. *Pinkett v. Brittingham,* 567 A.2d 858 (Del.1989) (rule preventing one party from compelling opposing party's employee from testifying inapplicable to doctor who performs independent medical examination and testifies strictly from own report).

In Delaware, a witness generally cannot be forced to offer expert opinions. Nor can defendant's employee be compelled to testify as plaintiff's expert witness.[FN17] This prevents a form of involuntary servitude,[FN18] with employees and experts being made to "serve without remuneration and without [their] consent."[FN19] It is no answer here, as Plaintiff argues, that the treating physician gave a deposition on which Plaintiff is willing to rely. The physician appeared as a fact witness. When Plaintiff asked the physician for her expert opinion, that drew an objection and the answer was given over the objection.

> FN17.*Montecinos v. Dickinson Medical Group, P.A.,* Del.Super., C.A. No. 94C-07-027, Ridgely, J. (Aug. 21, 1996)(ORDER); *Horne v. Kent General Hospital, Incorporated,* Del.Super., C.A. No. 85C-AP-29, Bifferato, J. (Aug. 28, 1990).
>
> FN18. See *State v. McLaughlin,* 514 A.2d 1139, 1142 (Del.Super.Ct.1986) (citations omitted).
>
> FN19.*Montecinos* at *1.

Moreover, as mentioned, when the physician offered an opinion about standard of care, it was not helpful to Plaintiff. Most significantly, the physician attributed the surgery's failure to the extensiveness of Plaintiff's congenital problem. And the physician did not see the swelling or Plaintiff's movement, whether caused by negligence or not, as even a significant factor in the surgery's outcome.

At most, the treating physician testified in deposition that along with several other possibilities, "motion of the neck ... can detract from the success of the surgery."As to the possibility of excessive motion and its effect on the surgery in this case, the physician testified:

Q: Is there any physical finding that you can rely upon to support a conclusion that excessive motion did not cause the failure of the surgery?

A: No.

Q: If you assume that subsequent to the massive edema there was motion, could that motion have affected the success of the surgery? And if not, why not?

A: It depends on how much motion. And I cannot say that didn't have an effect.

Referring to this case's facts rather than theoretical possibilities however, the treating physician further testified "There's nothing in the notes about excessive motion, and I don't recall whether there was excessive motion "And, as mentioned above, the treating physician attributed the surgery's failure to Plaintiff's congenital condition, not Defendant's treatment

As to the swelling caused by the I V infiltrate, the physician allowed that "if [Plaintiff] had significant swelling, that could cause airway obstruction with failure of the cricoid split and an inability to breathe adequately and comfortably after extubation "Along the same line, giving Plaintiff the benefit of several inferences, the treating physician testified the swelling had an impact on the timing of Plaintiff's extubation And the physician further testified that following the physician's schedule for extubation "decreases the complications, which are often pulmonary, and increases the chance of success "

***6** Plaintiff's complications, of course, were not pulmonary Moreover, the physician did not opine that any change in the extubation schedule had a bearing on the surgery in this case, much less that it increased the risk of failure here She also testified, "I don't think anybody knows the precise duration of intubation that's optimal There are sometimes circumstances about an individual patient that would encourage delay of the extubation "Again, the physician made no effort to tie the theory to this case's facts The only reasonable way to read the treating physician's explanation for what happened in this case is that the surgery failed because it failed

Finally, as to the expert testimony issue, the court appreciates that there is a scintilla of evidence that the child experienced pain due to the swelling and the minor surgery she underwent to correct it Nevertheless Plaintiff's proof establishes neither liability nor causation All of the above assumes that the physician can be forced to testify in the first place, which the court cannot do As it stands, Plaintiff has no medical expert witness and, as mentioned, she declines to find one

V

For the foregoing reasons, it appears that Plaintiff can present no medical expert testimony as to the deviation from the applicable standard of care by Defendant and as to causation of any injury to Plaintiff Thus, Defendant's motion for summary judgment is *GRANTED*

IT IS SO ORDERED

Del Super ,2004
Kern ex rel Kern v Alfred I Dupont Inst of Nemours Foundation
Not Reported in A 2d, 2004 WL 2191036 (Del Super)

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